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ABSTRACT

This paper describes the Winnebago County (Wisconsin) Community Options Program, begun in January, 1982, which provides for a comprehensive assessment of all elderly persons within the target area who are at risk of becoming institutionalized. The paper focuses on the planning activities for the first year of the pilot program including community inputs into design of the program, the process of involving community agencies at the start-up, and priorities set for client intake. The paper explicates the evolution of the assessment instrument for determining eligibility in the program and its use during the first year, and describes the service directory developed for client and agency use. Prototype case histories are offered from the 130 clients who had been served; in nearly one-half of the cases serviced, family members contracted for and provided in-home services out of program funds. As a result of needs brought to the forefront by the program, one new day care service was initiated through an institutional base (nursing home) and two others were projected. In addition, a private entrepreneur developed a for-fee service to match persons needing employment with older clients needing chore service. The program is conceived of as adjunct to an already well-established base of in-home services to elderly in the county. (Author/LLL)

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COMMUNITY OPTIONS

FOR ELDERS

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The Winnebago County (Wisconsin) COMMUNITY OPTIONS PROGRAM, begun in January, 1982, provides for a comprehensive assessment of all elderly persons within the target area who are at risk of becoming institutionalized. This paper focuses on the planning activities for the first year of the pilot program: (1) community inputs into design of the program, (2) the process of involving community agencies at the start-up, and (3) priorities set for client intake. It also explicates the evolution of the assessment instrument for determining eligibility in the program and its use during that first year, and describes the service directory developed for client and agency use. Prototype case histories are offered from the 130 clients who had been served. In nearly one-half of the cases serviced, family members contracted for and provided in-home services out of program funds. As a result of needs brought to the forefront by the program, one new day care service has been initiated through an institutional base (nursing home) and two others were projected. In addition, a private entrepreneur had developed a for-fee service to match persons needing employment with older clients needing chore service. The program is conceived of as adjunct to an already well-established base of in-home services to elderly in the county. There is a harmonious interface with in-home providers and nursing homes in this pilot effort. There is continuing need to educate medical professionals about the program and the many alternatives to institutional care.

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In addition, my thanks go to Patty Frohib, who produced a much lengthier and more detailed history of this program as an assignment for a class I taught last semester, Aging: Needs, Services, and Issues. She helped tremendously in getting my thinking organized for the paper.

Introduction

This paper is designed to convey to service providers and program operators some of the process and pitfalls of participation in a pilot program in the area of long-term care for older adults.

A preliminary evaluation has been done of the early implementation phases of the eight participating county pilot programs in Wisconsin. Additional surveys are being done at the local level regarding Winnebago County's program. Neither of these evaluations, at this point, have included study of cost effectiveness.

The paper was constructed utilizing minutes from the Planning/Advisory Committee, written reports on program progress by staff, interoffice memorandum, newspaper accounts, and interviews with key staff from the lead agency. It also included interviews with actual consumers of the program.

No attempt is made in this paper to evaluate either the long-range effectiveness or future of the Community Options Program in Winnebago County. In a true sense, the jury is still out. Initial positive reaction is found on the part of both professionals and consumers. Whether the level of service could be maintained without additional State funding is a matter of conjecture at this point.

Background

The Community Options Program (COP) in Wisconsin came into being as the result of a two-year planning process of the Wisconsin State Department of Health and Social Services and was written into law as a $3 million item in the 1981-1982 biennial state budget. Statutory language submitted for the proposal includes the following:

> "...an assessment shall be conducted for any person seeking admission to or about to be admitted to a nursing home (in participating counties) or in a state center for the developmentally disabled for extended care placement... The assessment shall determine the person's functional abilities, disabilities and need for medical and social long-term community support services. Each assessment shall include an investigation of long-term community support services that could serve as alternatives to institutional placement in a nursing home or in a state center for the developmentally disabled. The assessment shall include an explanation of the alternatives to the person being assessed and the person's family or guardian." [1]

In proposing this initiative, Wisconsin continued a long history of developing initiatives to meet the needs of chronically disabled and/or dependent persons (including the elderly, but not exclusively the elderly) which had begun in the 1970's. Immediately preceeding this effort was the completion of the Wisconsin Community Care Organization demonstration program.

Wisconsin Community Care Organization, a five-year U.S. Department of Health and Human Services sponsored demonstration program initiated in 1974 had, as one of its objectives, greater coordination of home care services in its three demonstration sites. Services provided were case management, including assessment, arranging for delivery of services, contracting for and

purchasing services and the monitoring of provider performance. The program was able to function and offer these services through a waiver of Medicaid requirements, which provided for intervention of persons in risk of institutionalization. In general, the demonstration results, while enhancing service delivery mechanism effectiveness through central control, did not substantially lower the rate of nursing home institutionalization, although the program proved cost effective when compared to the normal Medical Assistance program. An overall goal of the project, to enhance the quality of life for those in the control group of the experiment, was not borne out in fact.[2]

This pilot effort was to predict the later results of study by the U.S. General Accounting Office on 12 health care programs throughout the United States (December, 1982) which reported that although the demand for home health care will increase, and clients live longer and are more satisfied with their lives, these programs did not reduce nursing home or hospital use, or total service costs.[3]

A Long Term Care Policy Group, initiated within the Wisconsin Department of Health and Social Services, began meeting in May, 1980 to come to grips with national and regional concerns that Wisconsin examine its disproportionately high use of nursing homes and its lack of incentives for in-home care and community residential alternatives. At this time also, the Department was awarded a one-year systems development grant by the U.S. Department of Health and Human Services to facilitate this planning process for long-term care support. The Secretary of the Department of Health

and Social Services, in defining the charge to task groups noted the problems with Medicaid or Medical Assistance not being responsive either to individual or community based preferences. State costs for the Medical Assistance program, payable on a "as needed" basis, provided little incentive for local communities to develop alternatives to nursing home care and promoted the basic medical model in out-of-home facilities. Medical Assistance payments, coming directly from the state coffers, encouraged little coordination or planning among community support systems and residential based care.

Two separate task group assignments within the long-term care policy group affected the final design of the Community Options Program. These had to do with, respectively, rising Medical Assistance costs and nursing home pre-admission screening and community service integration. Guiding the two work groups were two major concerns that had been expressed statewide in long-term care. Foremost was the fact that Wisconsin had the second highest nursing home utilization rate in the nation. The nursing home population had increased faster than the elderly and disabled population as a whole, resulting in utilization of over 60% of the Medicaid budget within the state for institutionalization. As a result of this, expanded community services were becoming less frequent a phenomenon, with corresponding stresses placed upon the system by Federal threats of cut-backs in funds. All too obvious was the fact that Federal policy had consistently favored institutional care, although most elderly and disabled expressed preference for remaining in their own homes for as long a time as possible.

Wisconsin posited that the share of state funds to match Federal Medicaid funds could be utilized in a more humane and effective manner to provide choices for individuals as well as to stimulate greater coordination among agencies providing services--both within the community and among the various institutional entities. The Community Options Program was designed to utilize to the fullest available shrinking financial resources as well as enabling elderly and disabled persons who were at the greatest risk of entering nursing homes to remain self-reliant in their own communities.

Two other significant items in the 1981-83 biennium budget reinforced the thrust of the Community Options Program. A modest increase of $58 per month for recipients of Supplemental Security Insurance enhanced community agencies ability to arrange for living arrangements outside of their own homes, in an adult foster home or a small community-based residential facility. The other more significant development was a moratorium on new nursing home and hospital construction. The ultimate outcome of this "freeze" would be to potentially allow for even more latitude in community-based care during the 1983-85 biennium. Budget analysts projected that the cost of operating one new 180 bed skilled nursing home would be roughly equal to the total service budget of the Community Options Program for the biennium.[4]

Wisconsin State Statute 46.27, Long Term Support, Community Options Program, was made part of state law on January, 1981, upon adoption of the budget.

Description of the Community Options Program

There are certain broad underlying goals of the Community Options Program, as outlined in the state administrative plan of

1981. They are the following:

- to enable non-institutional community arrangements to serve as more effective alternatives to institutional care;
- to allow chronically disabled individuals greater choice and opportunity to lead lives as independent and valued as possible;
- to achieve greater coordination among providers of long-term support services; and
- to limit the need for institutional forms of care in a manner which will reduce the growth in institutional expenditures.[5]

Although emphasis was initially placed on diverting persons from nursing homes (including current residents of such facilities who wanted to be eligible for long-term supports in the community), the program also made eligible any persons who were about to enter state long-term care centers for the developmentally disabled. Theoretically, any age person was eligible to be served by the initial programs. State guidelines for eligible persons included persons who:

- have a long-term or irreversible illness or disability;
- are seeking, are about to be admitted, or are referred for admission to a nursing home or are current residents of such facilities;
- are included in a county plan for gradual program implementation;
- require ongoing assistance to attain or maintain stability and functioning;
- require at least periodic medical, restorative or rehabilitative care.

All criteria were to be met by each person entering the program.

The program was intended, over the four-year period covering two state biennium budgets, to divert one person in 10 from costly nursing home care. The amount of funding available to the program

was projected to average 42% of the cost of placing persons in nursing homes or developmental disability centers--the percent which was equal to the state's share of nursing home costs for Medicaid eligible persons. Because of the local unit of government non-involvement in previous long-term care planning (primarily fostered by the Medicaid reimbursement mechanisms) this program was targeted at primary involvement of county units of government. Therefore, the guidelines designated one of three entities eligible to administer the program: county departments of social services, combined community services boards, or a community human services board.* Each county board of supervisors was responsible for designating one of these three agencies to administer the program. Early involvement of the powerful and pivotal Wisconsin County Boards Association was sought to ensure sanction at the local level.

To test the feasibility of the program, the state 1981-83 biennium budget provided for eight pilot counties to participate in the program during the first year. The rationale for the selection of these eight "pioneers" was to enable realignment of organizations and professional practices without disruption, undue cost and additional burden of state administration for the program, while at the same time encouraging broad participation and consultation. The selection of the pilot counties was based on rural-urban mix, per capita income and elderly population: all factors which have been used as indirect indicators of demand for nursing

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*In Wisconsin, combined community services boards channel state funds to counties for programs for the chronically mentally ill, alcoholic and drug abusers. Combined human services boards deal with the problems of the physically or developmentally disabled.

home care. Selection of the pilot group was made in October, 1981, after the State Department of Health and Social Services had received letters of intent for participation by 17 counties. A screening committee, composed of representatives of health and social services providers and consumers, health systems agencies, area agencies on aging, and the Department itself made the final selection.

Basic program components which were to be carried out by all counties involved assessment, case planning and service delivery and case management. The program operations were envisioned to ensure the minimum level of assistance to persons who wished to stay in their own homes and/or communities rather than enter institutional care. The system would operate in this manner:

- Each person planning to enter a nursing home, considering a nursing home placement, or in risk of nursing home placement (as defined by community professionals) would be offered the opportunity for an assessment of total needs. The individual could waive his/her right to the assessment process, but Medical Assistance would only pay for nursing home care if the assessment had been done.
- The individual, following the assessment process, would be offered an array of community services designed to meet his/her needs, comprised of both formal and informal community supports. Capability of other caregivers would be assessed to determine the strength and willingness of the support potential for individuals. The older or disabled person then would choose from the available options.

- A case plan would be devised arranging for the services to be provided to each individual, which would combine funding sources available from various programs as well as taking into account private ability to pay. An estimated average of $336 per month was projected to be available to finance the various services needed from the Community Options Program itself. (This was in addition to other services funds generally available from Title XX of the Social Security Act, Medicaid Home Health funds and Title III of the Older Americans Act.)
- A regularly scheduled plan and review of action for each individual would be the responsibility of a lead administrative agency, although not necessarily the responsibility of a single case manager within a lead agency. Maximum flexibility was allowed to counties participating in the pilot phase in this regard.
- Each county program would be guided in the development of the program by a county advisory committee comprised of representatives that were strictly prescribed in the state legislation. This interagency long-term support planning and advisory committee was to ensure that the Community Options Program utilized county resources and personnel to the maximum extent in carrying out the program. At a minimum, the committee would have at least two representatives receiving long-term community support services, one elected county official, a county health representative, a representative of the county department of social services, a representative of the combined community board, and one representative from the county commission on aging (local planning body for Title III Older Americans Act

funds). An addition to this committee, where practical, might be a physically disabled person.

Winnebago County As Pilot

The eight pilot counties who initiated the Community Options Program in January, 1982, varied considerably in size, income, elderly population, and availability of nursing home and hospital beds. Collectively, the pilot counties had accounted for 12% of the admissions to nursing homes in the state in 1981 where Medicaid reimbursement had been claimed at the time of admission.

In terms of total population, Winnebago County ranked third highest among the eight pilot counties. Three other counties in the group had a much higher population of rural elderly (one county having 100% rural population) than Winnebago County; although considered primarily a "rural county" in the scheme of things, the percent of rural population is about 21%. This reflects the concentration of most of the county's population in two major towns, with much less dense population throughout the remainder of the county. In terms of population 65 years plus, Winnebago County nearly fits the national profile--about 12%. In the pilot group, this county also reflected the third highest number of nursing homes, with an occupancy rate of 90% and 73 licensed beds per 1,000 population over age 65 years. Winnebago County reflected a high number of hospital beds per 1,000 population.

Winnebago County's entry into the program was based on several additional concerns outlined in their letter of intent, September, 1981. Although service development in general had been fairly highly advanced, service development for the elderly had not kept pace with other areas. For example, there was no day care for the

elderly, little respite care, and a short supply of licensed facilities to provide temporary care. Further, there seemed to be a lack of knowledge among service providers of the capabilities and full range of services for the elderly and a need for more public information regarding these services throughout the larger community.

Winnebago County, however, has had a long history of developing innovative programs in the community, and this was also one of the primary reasons for its participation in the Community Options Program. For example, it was the first county in the state to employ a homemaker staff, one of the first counties to develop volunteer services as an adjunct to Federal/State resources, one of three counties in the United States to pilot the use of foster care for adults, had conducted community and public meetings to assure that nursing home admission on the part of families was made with full knowledge of availability, and had worked closely and harmoniously with community nursing homes to offer alternatives within limitations of funding and staff. As soon as notified by legislative representatives from the area that program funds were being proposed, informal talks among various community agencies such as the social services department, the community mental health and health organizations, area hospitals, public and private provider agencies and nursing homes were initiated. In addition, support had been garnered from one of Wisconsin's leading industries--the Kimberly Clark Corporation--and the University of Wisconsin-Oshkosh, both of whom had established positive collaborative arrangements with community agencies regarding needs assess-

ment and services to the elderly. Statewide, the Winnebago County Department of Social Services (in particular, its administrator) is known for a propensity to participate in new pilot programs available to the state or the counties. As for its application for participation in the Community Options Program, the timeliness of availability of funds coincided with a two-year frustration of the County in not having adequate resources to meet massive home-health care requests. Winnebago County had previously applied to be a demonstration site for the Wisconsin Community Options Program, but was not accepted. This application was the culmination of intents and purposes toward developing broader and more extensive locally-controlled long-term care services.

Planning Activities

In November, 1981, the chairman of the Winnebago County Board appointed a 12-member Planning/Advisory Committee, consistent with state administrative guidelines. The Chairman of the Committee was a member of the County Board of Supervisors, and a private real estate developer. Three other members were from the County Board of Supervisors--one the Chair of the social services board, another representing the combined services board, and the third a member of the county board health committee. Three consumer members were appointed, two of them representatives of elderly services and the other a physically handicapped individual. Additional membership included a hospital discharge planner, the Executive Director of one of the largest nursing homes in the area, the director of the Visiting Nurses Association, a physician, and a representative from industry (Kimberly Clark Corporation). As prescribed in state

guidelines, the Planning/Advisory Committee was to study the need for developing resources within the county to meet long-term care needs, to recommend administrative procedures to implement the program, and to develop and implement the local plan for operations.

A chronology of developments occurring within the planning process of the Committee illustrates local concerns, factions, and options. This Committee worked from November, 1981 until late March, 1982 when the local plan was submitted to the Department of Health and Social Services.

At the first session, the County Executive was present to present the purpose of the program and outline state restrictions on operations. The Chairman of the Committee, with a certain amount of pride, set the keynote for the planning process when he stated that this was not a new program with new objectives, since county agencies had always attempted to keep people in their own independent living situations. This tone served to alleviate some of the tension that had been building in the community on the part of service providers who saw the pilot program as a criticism of their effectiveness in providing appropriate services to handicapped and the elderly.

This particular ambiance of the planning committee in this early phase perhaps later proved to be a self-fulfilling prophecy. While neither attractive to or disattracting from the overall goal of the program, this philosophy contributed to the ultimate integration of the program into the overall services of the lead agency. During this first session of the Committee, it was assumed, though not explicitly stated, that the Winnebago County Department of Social Services would be the lead agency for administrative control and financial reporting.

As outlined in this first meeting, the members of the Committee agreed to devote their time and energies to two distinct products: (1) recommendations on the screening and phase-in process, including development of a universal assessment tool, and (2) an inventory of community resources and services to meet the needs of the program. Subsequently, almost weekly meetings for the first three months of the process were conducted by both subgroups.

The inventory analysis committee's brief charge was to identify the population to be served, by general characteristics and types of disabilities, as well as to develop target groups for the phase-in of the program. Central to that charge was a review of the nursing home admissions population: the characteristics of persons coming to nursing homes, the sources of referral, and the lack of services in the community which may have led to their admittance in the first place. Members were to talk with hospital discharge planners and long-term care providers. Two possible sources of information, a 1980 survey of the population and characteristics of nursing home residents, and a Department of Social Work study done two years previously (in one nursing home) were available as written resources to the Committee. Early in the procedings, attention was brought to bear on the fact that this program should not concentrate solely on elderly persons or those in nursing homes; that the developmentally disabled were also part of the overall target for services in the larger program.

Technical assistance was provided by the Wisconsin State Department of Health and Social Services to the inventory analysis product in the form of 35 assessment tools that had been collected

nationwide which could be considered as assessment instruments by participating counties. Needless to say, this confounded the Planning/Advisory group and provided little concrete guidance. In order to be eligible for Medicaid nursing home funds, hospital discharge planners were required to utilize a format called the Patient's Plan of Care (PPOC). This entirely medically-oriented form included recommendations for only skilled nursing facilities, intermediate care facilities, community based residential facilities with one small line devoted to "other" plans. Although information on this assessment may have seemed adequate to cover a plan of care for nursing home residents, it hardly seemed adequate to meet the total social and health assessment of the Community Options Program. Local hospitals expressed concern of their staff being overburdened in preparation of the necessary forms, resulting in additional hospital stays of patients and loss of income to hospitals because of the cut-off dates prescribed by utilization review. The response of representatives on the Planning Committee to an assessment tool, very early in the process, was to utilize the existing PPOC already in place at two area hospitals. In a seeming contradiction, the larger Planning/Advisory Committee recommended that personnel already doing assessments should continue to do so to conserve COP funds for direct services.

Although negotiations continued within the subcommittee, and the Planning/Advisory Committee at large, a single assessment tool was not agreed upon by all of the participants for the screening effort. The final assessment tool, which combined social and medical information, is currently utilized by the Department of Social Services and the Unified Services Board. The hospitals

steadfastly refused to use any other instrument for screening other than the one that they had always used for Medicaid-eligible persons. The nursing profession adopted a modified format (from the hospitals) and incorporated additional screening information into the overall content.

In the final analysis, six different agencies were certified to perform the assessments for the Community Options Program: two hospitals, the County Nursing Service, the Visiting Nurses Association, Department of Social Services, and the Unified Services Board. Due to utilization of different assessment tools, uniform data on clients is difficult to obtain. However, staff of the program maintain that there is uniformity due to their maximum communication and coordination revolving around the case plan. All assessments include that of a nurse, although all assessments may not include input by other medical personnel or social workers. Therefore, the program would appear to emphasize consistent data on clients along health lines.

The charge to the Community Resources and Services Committee was to identify what services existed in the community to meet long-term care needs, to document which services were presently being utilized and to identify gaps in services that might be financed through COP funds. As the services committee began to meet regularly, an additional member was added, a representative from Upjohn, Inc. This major service provider had supplied home-health care services to social services clients for several years. This subcommittee also had as a member a representative of one of the other largest health care cost consumers in the area--the director of a large nursing home. Both of these representatives

proved to be valuable additions to the committee since they kept the focus of the Community Options Program on the full continuum of care, resulting in nursing home admissions for clients as well as provision of in-home care services.

Members of the services committee designed an inventory format which was utilized to produce a computerized listing of community services. This listing currently is updated on a monthly basis through the computer. The current directory contains listings of alternate living programs, attendant care, blind services, chemical dependency counseling, clearning services, congregate meals programs, day care providers, discount programs, emergency funding, escort services, first aid training, friendly visitors, home consultants, home delivered meals, home repair and maintenance, home sharing, hospice housekeeping, information and referral, legal services, health care, nursing homes, recreation services, sheltered care, transportation and housing, to name a few.

The services subcommittee identified some needed services that the Community Options Program would stimulate. The need for more adult foster care was identified in the early planning phases; meals on wheels programs would later be provoked to grow with emphasis on in-home care; there was no day care in the community for physically disabled persons, marginally employed or older people; in particular, there was lack of a range of alternative housing. Although there were adequate number of nursing home beds in the area (except for geropsychiatric needs) there was little available rental housing, no congregate housing, and no shared housing. In addition, the subcommittee saw a need to develop respite care on a 24-hour basis, and to develop coordination of

existing volunteers to include neighbors, elderly persons themselves and relatives.

As a result of a questionnaire sent to over 40 community agencies, priorities for funding within the Community Options Program was set in early January, 1982. These were, in priority order, home care services, respite care, community understanding of services available (public relations), meals programs and supervised congregate living. The program would also utilize supportive home care funds (Title XX) and personal funds to supplement cost of services. To date, one new program in the community has been developed as a result of COP: adult day care. Currently, a local nursing home serves between four and five clients daily in a supervised program of supportive and personal care. A social-model day care center is about to open (after many months of problems obtaining funding and space) which is sponsored by a church organization. The housing needs expressed in the initial survey have not been addressed at this point.

Early in the planning process, the decision had been made not to utilize a single person as case manager, or even a single community agency. The Department of Social Services assumed the function of service manager, accountable for funds and for administrative reporting. The philosophy of the lead agency was expressed by one of its representatives early in the planning process: the reason behind the agency making application for the funds was to conserve dwindling home care dollars, add additional funds to home care dollars, and be able to shape the guidelines of the COP program for the future. As such, it was viewed as an "add on" to

present services, not a distinct entity within itself. As the planning process continued there were pleas for a central manager of the program; this was resolved many months later by appointing one of the older adult service supervisors from the Social Services Department to serve as the principal liaison to the program. This arrangement has led to enhanced coordination and communication among agencies. Theoretically, however, any staff from one of four agencies may be the "manager" of an individual case plan, once assessment is completed: County Nursing Services, Department of Social Services, Unified Community Board of Visiting Nurses Association. Depending on the primary purpose of each of these agencies, clients may receive very different kinds of services. Currently, the case manager function has been absorbed throughout the entire Department of Social Services. Older and younger adults and physically and mentally handicapped persons may be served by a number of "units" within that Department.

One additional committee was formed during the planning process: the Publicity Committee. This group was responsible for preparing material to convey the purpose and operation of the program to the community at large. Various participating staff were recruited for radio talk shows, a speakers' bureau was organized with representatives from the Planning/Advisory Committee and staff from the lead agency, and newspaper publicity and a brochure were prepared. It was also up to this committee to form teams to do indepth education with physicians in the area. As the COP began its operations, it became obvious that a great many physicians were not knowledgable about the program and were still referring persons

to nursing homes where other alternatives might have been made available.

One problem area consumed a great deal of time and energy of the Planning/Advisory Committee. A county supervisor had proposed that unemployed persons in the county receive training from the local technical and vocational school to provide personal care to clients of the Community Options Program. A curriculum plan was presented to the Committee for its approval. There appeared to be a need for additional workers throughout the county with this training. Due to the strong feelings of representatives from the medical profession (particularly the nurses) on the Committee, the plan was finally abandoned. A rationale proposed for abandoning the plan, however, had to do with the program not being able to provide liability coverage for independent supportive home care providers while in clients' homes. The training still goes on, but the curriculum no longer covers any matters concerned with personal care. When trained, workers are put on a list which family members and relatives may utilize if they need maintenance, housework, or chore service performed.

Service Provision

At the end of the first nine months of operation (the first year of the pilot) the Winnebago County Community Options Program had enabled 99 elderly and handicapped residents to remain in their own homes and out of a nursing home. From this number, COP funds were used in only 37 of the cases to actually provide services; the remainder of the costs were paid for from personal or family resources. One hundred sixty-four persons had been referred to

the program; 145 persons had been assessed. Ninety-nine were able to remain at home, while 46 went into nursing homes. Virtually all of the clients of the program are over age 60. Client cost averaged $397 monthly (the average set by the state for service had been $402 monthly). Eligible for service in the first six months of the program were persons from the community at large who were Medical Assistance eligible; during the second six months, persons accepted for service were those who would be eligible for Medical Assistance within six months of the assessment. Also at that time, persons with private ability to pay for services were accepted for assessment. The bulk of referrals came from hospitals; the major portion of funds was spent on home-care. Categories of home care included licensed nurses and therapists (professional services), supportive personal care and housekeeping and chore service tasks. The assessment rate, which is absorbed by the assessing agency with no cost to the program, is $17 an hour. In the beginning of the program, an assessment could take as long as four hours. However, with a refined assessment tool, the process is not as lengthy. Inservice training for staff, proposed early in the planning process, had not been accomplished during the first year, although plans are now underway for doing so.

Of a sample group of 44 clients who were assessed between May and September, 1982, 38% were receiving COP-funded services; 32% were receiving services from agencies not funded through the Community Options Program, 4% had neither required nor received any COP services, 7% had entered nursing homes, and 19% were deceased. The most frequent reasons given for withdrawal from the

program are death and placement in a nursing home. The average age of clients served was 79 years.

The range of services available to clientele in the Community Options Program is virtually unlimited, except for the housing services seemed necessary but not available in the local community. Typical situations are these:

- Meals on wheels provided to a couple who are otherwise able to care for themselves;
- Four hours per week respite care for an individual with a handicapped spouse;
- Round-the-clock personal and nursing care for an extremely old or disabled client;
- Cleaning and chore services one day a week for an elderly couple;
- Training for a wife in personal care at a local educational institution so that she may care for her disabled husband;
- Funding for a neighbor to come to a home one day a week to do errands, shop and take care of correspondence.

A very high level of care is provided by family members and other relatives.

One unique aspect of this program is that individual clients arrange for the needed services. This may involve contacting persons from an available list provided by a service agency, or it may mean advertising in the newspaper for the kind of help desired. Payment is then made to the client, who reimburses the appropriate helper. Payment for all services are funneled directly to the client, except for Upjohn, Inc. who provides home-health care under contract with the Department of Social Services (this contract preceeded the Community Options Program). The requirement that clients interview and screen their own service providers is felt to be a necessary ingredient in ensuring consumer satisfaction with the program.

Although a full-scale evaluation of the first year's experience is now underway (both at the State level and at the county level), a preliminary consumer satisfaction survey was conducted by staff of the Social Services Department for 10 persons who had been assessed through the program. Quality of service was ranked "excellent" by eight of 10 persons assessed. The most frequent source of information about the program was the Visiting Nurses Association, although others had heard of it through newspaper articles and social services staff. All persons interviewed had a clear idea of who their case manager agency was, but an amazing lack of understanding when and how they actually got into the program. The interviewees recall meeting with several representatives from several agencies. Knowledge of community services had increased as a result of the program's operation. The chief complaint about the program had to do with "excessive paperwork." This refers to reporting required and documentation of costs for the individual client to be reimbursed for services. No major recommendations were made for improvements in the program.

Case Histories

I. Charles S. is the owner of a small business in a blue collar area of one of the county's larger communities. For almost a year, he received services for his 89-year old mother through the Community Options Program. Prior to that time, the family had paid almost $100,000 in a two and one-half year period for care for his mother in her home--a home nearby to where Charles and his wife live. He remembers his reluctance to enter into the program; however, financial and psychic resources were exhausted at that point. For the year, round-the-clock nursing care was provided for his

mother through the program. Although he personally interviewed all staff coming into his mother's home, he recalls that some staff were not responsible to their duties; he felt an extra burden placed on him to see that proper care was ensured. When scheduled caretakers did not show up at the appropriate time or day, this disrupted his business. Finally, he stated that the "excessive paperwork" (interviewing, reporting, and doing Social Security withholding for caregivers) and his mother's worsening condition, led him to place her in a nursing home. He currently reports having been very happy with the program, but feels that inservice training for all staff associated with the program is a real need.

II. Sally H., age 66, is totally confined to a wheelchair: a cerebral palsy victim. Although requiring up to four hours of personal care per day to assist with her daily living, she reports a totally "independent existence." She has an apartment of her own in a housing complex run by a residential facility. She does her own shopping, cooking, bookkeeping, and travels about the town on public transportation. She is the chairman of the Sunshine Committee in her housing complex, and is active in several community and church groups. Prior to moving into her apartment, she had spent three and one-half years in a nursing home--placed there after her own parents, who she had cared for most of her single life--had died. She became an advocate for her own cause of moving out of the nursing home, and mobilized community resources to accomplish that goal. Several agencies were involved in planning for her eventual "release." Fortunately, the Community Options Program came along at about the time that her advocacy efforts had accomplished their purpose. She is a free and independent lady, and values the privacy of her "own home."

Conclusion

Several key observations regarding the Winnebago County Community Options Program have been discussed with key staff from the lead agency.

The perceived success of the Winnebago County pilot is based on the premise that this particular county had many resources available for long-term care going into the program, and therefore the pilot effort was merely a matter of coordinating exisiting services. The program was seen, essentially, as an adjunct to home care services, not as a new program or one that would establish new patterns of service delivery. In fact, the Community Options Program funds have greatly expanded home-health care in the county. As a result, the pilot did not see the growth of new programs, as many of the other pilot programs had. The fact that clients cannot recall their entry into the program is perhaps explained by the fact that agencies continued service to clientele with new program funds! In many cases, the same caseworkers or nurses conducted a plan of care that had existed for several years.

In this pilot effort, there is a noteworthy happy marriage between in-home service providers and the nursing homes of the community. The administrator of the Social Services Department seized the opportunity to promote this happy relationship very early in the program by involving nursing home operators in informal discussions as well as appointing representatives from their ranks to the Planning/Advisory Committee. The author is aware of only some small talk, early in the planning phases, about threats to nursing home income because of this program. This kind of discussion has largely disappeared as the program has progressed. Once

trust was established in the assessment process, it was obvious that not all persons were not physically or mentally able to remain in their own homes in the community, and that referrals would continue to be forthcoming for nursing home care.

Medical professionals must be constantly kept alert as to the potential for in-home care vs. institutional care. This fact has been a continuing thread throughout the operation of the Community Options Program. Educating the medical professionals about the program will continue to be a long-term care project in its own. In addition to this, awareness of the "turf" of medically-oriented professions working in this kind of program needs to exist. At times in the operation of the county pilot, "turf" became a disruptive factor in implementation. This is especially seen at the time when the community proposed utilizing home-health care workers who were not trained by the medical profession itself.

It would be easier to evaluate and to make recommendations for change within the Winnebago County program if there had been one uniform assessment tool, and if there had been a single case manager assigned to a particular client. As the program has been structured, an indepth research project would be difficult, at best, to achieve. There are far too many variables.

Finally, although inservice training for involved staff had been prescribed early in the planning process, this was not achieved. At present, the inclusion of training has been just started. Clientele feel a need for this; service agencies have achieved remarkable success with the program without this component.

Increasing numbers of elders--especially the old-old--will make this program more viable in years to come. Although not necessarily proving less costly than institutional care, families and individuals prefer to have available community options for elders.

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